Medicare Override Request for Drugs

Client Name _____

Client ID Number (RIN) _____

Pharmacy Name _____

Pharmacy Provider # _____

Pharmacy Phone # _____

Physician Name _____

Physician ID (DEA or state license) _____

Physician Phone # _____

Drug Name _____

Drug NDC _____

Diagnosis _____

_____

_____

Date of organ transplant if applicable _____

Type of cancer if requesting Zofran _____

Medicare reject reason or attach copy of EOB _____

Date of Service _____

Provider Signature _____

Date of Request _____

Fax (217) 524-7194